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HUMAN RIGHTS AND SCIENTIFIC AND TECHNOLOGICAL DEVELOPMENTS

Written statement submitted by Disabled People's International, a
non-governmental organization in consultative status (category II)

The Secretary-General has received the following communication which is circulated in accordance with Economic and Social Council resolution 1296 (XLIV).

[12 February 1991]

1. Disabled Peoples' International has been intensely involved with the Working Group of the Commission on Human Rights on the Question of the Draft Body of Principles and Guarantees for the Protection of Mentally Ill Persons and for the Improvement of Mental Health Care (Working Group) in its deliberations over the text of an international instrument to protect mentally ill persons. 1/
2. During last year's session of the Working Group, we made substantial progress toward a final text. However, a number of key issues were left to this year's session, and one controversial provision was adopted last year after the DPI delegate had left Geneva. During the 1990 session, during which DPI was represented, the Working Group finished its work on the draft. The draft, now called Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, 2/ is now before the whole of the Commission on Human Rights at its forty-seventh session.

PROBLEM AREA - INVOLUNTARY ADMISSION

3. There is one major area where the draft is less than satisfactory from a DPI perspective: the involuntary admission process, approved by the Working Group, the last day of the 1990 Working Group, when the DPI delegate, because of severe shortage of funds, had had to return home. This process (principles 16 and 17 of the draft) allows involuntary admission upon the

authority of a "qualified mental health practitioner" in two circumstances: (1) where there is imminent harm to the patient or to others, or (2) there is a likelihood of serious deterioration in the patient's condition (principle 16). When there has been an involuntary admission, the decision must be brought before a review body "as soon as possible" after admission.

4. The DPI position was (1) to require that the initial involuntary admission (commitment) to a mental health facility require either approval of two mental health practitioners or an independent judicial procedure (i.e. the person comes before a magistrate); (2) to require that any involuntary admission be brought before the review body within 72 hours; and (3) to delete the "serious deterioration" standard entirely.

5. The reasons for this position are quite clear:

(a) Involuntary admission subjects a patient to treatment without consent (see principle 11). Therefore, more assurances of impartiality are needed for initial involuntary admission than the recommendation of one mental health practitioner. As we have seen in too many countries, parents use "family" doctors to have their "problem children" (the "children" are in fact adults) committed;

(b) Almost all drugs given patients involuntarily are not drugs that cure mental illness; usually, they are drugs that pacify patients so as to ease staff burdens in the institutions. Accordingly, no one is going to be medically harmed because of a delay in the ability to give drugs that might be caused by requiring a judicial or magisterial procedure;

(c) Most drugs administered, especially the phenothiazines, have irreversible side effects. If they are not medically needed, they cause a secondary disability, sometimes called drug-induced personality. There should be full review before these drugs are involuntarily administered.

(d) The ability to commit persons based on a "deterioration" standard causes jurisdictions with short funds to bypass community care, where on an out-patient basis a patient is likely to agree to medically sound treatments. This is what has happened, for example, in the United States. There, mental patients all too often have no community care at all. These persons become homeless street people. When they get bad enough ("deteriorate"), the jurisdiction sends them away for a week or so (using special federally-mandated funds that only covers hospitalization) and when they are severely pacified with drugs, they dump them back onto the street. When the medication wears off, the cycle repeats. DPI considers this cruel, inhuman and degrading treatment, and a violation of the right to medical care. For jurisdictions that do not abuse patients in this fashion, limiting the involuntary admission standard to a danger to self and others is no burden;

(e) Prompt appearance before the review board is essential to add protection against abuse in drugging and in commitment. Because the patient is entitled to the right to counsel at the review body stage (principle 18), there is the assurance that the patient will have an independent advocate. DPI maintains that "as soon as possible" would be construed to mean weeks if not months in some jurisdictions, clearly far too long. DPI maintains that persons deprived of liberty rights because of alleged mental illness ought to have the same protection as is available to persons detained for alleged criminal acts;

(f) Involuntary admission should truly be a last resort, when all other meaningful medical treatments and less restrictive settings have clearly failed. The burden should clearly be on the jurisdiction to prove that the treatment is life or death, that all other treatments have been tried, and that the institution and the proposed treatments are truly beneficial. After all, the person risks his liberty rights, one of the most important human rights. And as DPI has maintained, people do have a right to be different. Some societies have very narrow ranges of acceptable behaviour. Those who do not meet the test are labelled disabled and put away;

(g) Even the best of countries abuse the involuntarily admitted patient. DPI does not believe Governments should be left with mere monitoring to see that there is no abuse. The patients themselves and their advocates must be given every opportunity to defend themselves against abuse.

PROBLEM AREA - COMMUNITY CARE

6. A second, though smaller, problem area involves the mandate for community care, normalization and deinstitutionalization (principles 7, 8 and 9). DPI urges that the community care mandate be strengthened - especially in light of potential abuse in the involuntary admissions area.

RECOMMENDATIONS

7. DPI proposes the following changes in the text of the principles:

(a) Principle 16: substitute "independent authority" for "qualified mental health practitioner". Delete criteria 1 (ii): involuntary admission based on a "serious deterioration" standard;

(b) Principle 17: substitute "within 72 hours" for "as soon as possible" in section 2;

(c) This is a critical issue for DPI and all persons with mental illness. We anticipate that the principles, with our recommendations, will provide substantial improvement in the enjoyment of human rights of persons with mental illness. The instrument will also be a fitting one to promulgate in the closing year of the Decade of Disabled Persons.

Notes

1/ See our Report to DPI regarding last year's session of the Working Group, as well as our 1988 report to the Sub-Commission, our written statements published as E/CN.4/Sub.2/1988/NGO/27 and E/CN.4/1989/NGO/75, and various other memos.

2/ The Working Group chose to call the segments of this instrument "principles" rather than "articles". Most human rights instruments have "articles". However, some instruments use "principles" and are considered of equal weight to United Nations declarations or instruments using "articles".
